Newsbriefs

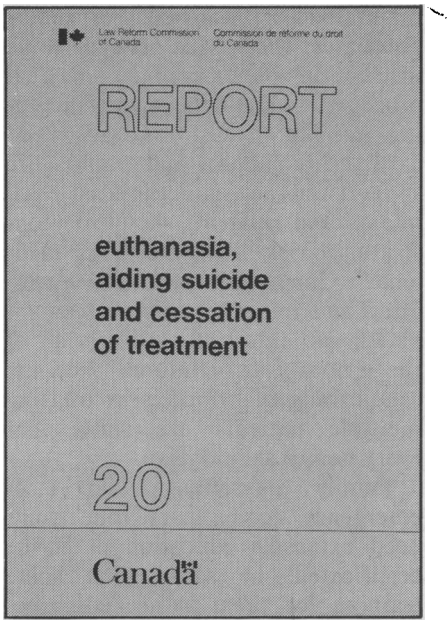
Law Reform Commission recommends euthanasia remain in Criminal Code

Proposals by the Law Reform Commission of Canada for changing the laws governing when and how doctors may treat or stop treating their patients amount to little more than recommendations to define more clearly what is already being practised with the public's knowledge and consent.

When a patient is not benefiting from treatment, a physician should be able to stop the therapy without being held criminally liable. When a competent person refuses any kind of treatment either permanently or temporarily, a physician should not be required to administer it. In the case of a dying person, a physician should be allowed to administer only the appropriate palliative care even if therapy is likely to shorten life. These are the commission's three major proposals for amending the Criminal Code, proposals that would only eliminate "the ambiguity unintentionally created" by the present law regarding the discontinuance of treatment.

Interpreted literally, the law appears to place an unqualified duty on the doctor to administer treatment once begun even if it has become useless or unreasonable.

The three basic principles underlying the proposed amendments are widely accepted in Canada. First, the presumption in favour of life should always be recognized. Unable to consent to or refuse treatment, an unconscious person should be presumed to want to live. The physician's duty is to help the patient unless the treatment would be useless or unreasonable. Second,



people must remain masters of their fate. Forced medical therapy on competent individuals should be considered assault, an offense that can be penalized through existing law. Third, if a patient's decision is more concerned with his quality of life than his staying alive as long as possible, such consideration should be respected by the physician. When a person is unable to make a decision because of age, unconsciousness or mental handicap, the law should and does have special provisions for substituted consent.

Though these principles are being adhered to and the commission's recommendations are already being practised extensively, and though many Canadians are under the impression that these measures are already explicit legal policy, the study which began in the fall of 1982 has a clear and urgent goal.

In its final report, entitled "Euthanasia, Aiding Suicide and Cessation of Treatment", the commission describes how health care professionals "frequently indicated how ambiguous, imprecise and vague they find the existing provisions of the Criminal Code". Moreover, the report says, "The ambiguities and doubts encourage some physicians to be excessively conservative in the practice of medicine."

With regard to the questions of legalizing or decriminalizing voluntary active euthanasia, making mercy killing a separate offense from homicide and of decriminalizing the act of aiding suicide, the commission recommends the laws not be changed.

Canada could not tolerate euthanasia "without violating its social traditions and history", the report says. The legalization of such a practice is unacceptable "because it would indirectly condone murder [and] because it would be open to serious abuse".

Mercy killing too, if it has its own legal definition apart from ordinary murder, would open the door to abuse. The biggest problem would arise in the need to determine the "purity" of motive of the accused, something the commission says would be extremely complex and difficult to prove. The report favours keeping the law as it is now because it gives authorities discretion to allow the accused to plead guilty to a lesser charge or, in exceptional cases, they can decide not to prosecute.

To help someone commit suicide could be done for other then altruistic motives, the commission says, and therefore the act should not be decriminalized.

The final report has been presented to Cabinet. Though Justice Minister Mark MacGuigan has said the three proposals dealing with the cessation and refusal of treatment won't be acted upon immediately, in

all likelihood they will eventually become law. However, the commission emphasizes early in the report that doctors and others must not regard the reforms, once they have been adopted, as "a detailed guide for solving the complexities inherent in every individual case . . . It would be an illusion to believe that the Criminal Code can provide a comprehensive guide for making medical decisions."

The recommendations are meant to help clear up misunderstandings for those who must regularly make the types of decisions involving when and how treatment should be continued or stopped. The proposals also attempt to clarify the rights of patients who should know "what to expect and insist upon from the medical profession", the report says.

Family physicians can staff emergency rooms, says CMA report

Family physicians should continue to work in hospital emergency departments but they should be appropriately trained to practise this type of medicine.

This is one of the main recommendations by the Canadian Medical Association's Council on Medical Education, which just completed its report of a survey of emergency services in Canadian hospitals.

Growing public demand for immediate attention to medical problems in emergency rooms and outpatient departments has accelerated the trend toward increased activity and high specialization in emergency medicine, prompting the council to carry out the survey. "We wanted to find out what kinds of doctors regularly work in emergency rooms and what their training levels are", says Mr. Joe Chouinard, coordinator of the council. "We needed background information to help us determine what the education requirements are for ER care."

The 1982 study, which divided 200 hospitals according to the number of emergency room patient visits per year, tried to determine emergency room arrangements generally, including what hospitals hire full-time emergency care doctors and which maintain emergency room coverage using all physicians on a rotating basis. "We found that those departments with large ER volumes tended to hire full-time doctors but that family physicians still do their fair share of the work, deliver a significant amount of ER services", says Chouinard.

Based on the council's findings, the CMA has recommended a number of measures to ensure the standards in emergency room care are maintained or improved. For undergraduates, the CMA believes some instruction in emergency medical procedures should be given, including training in basic and advanced cardiac life support and trauma life support for the acutely injured. "All interns and residents should demonstrate their skills in emergency medicine", Chouinard says. "The evaluation and initiation of management of ER patients, the stabilization of the seriously ill or injured" and the establishing of priorities in treating multiple patients are skills that every doctor should have.

Family physicians who staff emergency rooms part time don't need extensive education or to be certificated, he says, "But some training for them is needed, especially for doctors in smaller hospitals which aren't equipped to handle everything, or which don't have access to a variety of specialists." For example, if a car accident happens near a small city, any doctor at the city's hospital should be able to provide competent care for the victims until they can be stabilized and transported to a major centre.

The CMA has recommended that hospitals that provide training programs or training rotations in emergency medicine should have emergency departments directed by certificated physicians.

What exactly should be the role of family physicians in emergency rooms has not yet been worked out. One of the council's major activities over the next year, in conjunction with the CMA's Council on Health Care, the Canadian Association of Emergency Physicians and the College of Family Physicians of Canada, will be to develop a comprehensive definition of the role of the family doctor in emergency rooms.

Chouinard says general practitioners should be aware that the CMA is looking out for their interests in trying to keep them in emergency rooms at a time when the trend is toward higher specialization. "There is no need for all ERs to be staffed solely by emergency room physicians", he says. "Patients receive better care in many cases from family doctors" because most emergency medicine still involves minor problems such as sore throats and ear aches.

The survey report, "Emergency Services in Canadian Hospitals", is available at $5 a copy from the Council on Medical Education, CMA House, 1867 Alta Vista Dr., Ottawa, Ont. K1G 3Y6.

DRG payment scheme gets mixed reviews in United States

Medicare's new prospective payment scheme — by which American hospitals are to be paid predetermined fees for services they provide Medicare patients — went into effect Oct. 1.

The scheme is intended to control a spending binge that has seen Medicare expenditures soar an average 19% annually since 1979. Government health care bureaucrats have warned that if this binge is not curtailed, Medicare, which subsidizes health benefits for up to 30 million of the nation's elderly and disabled, will run out of funds by 1990. What differentiates this plan from the many cost containment devices previously attempted is its rejection of cost-base reimbursements — by which hospitals were paid for any and all costs expended on their Medicare patients — in favour of fixed rates set in advance according to the patient's diagnosis.

These payments are based on Diagnosis Related Groups (DRGs) covering each of 468 illness categories. DRG prices are based on nationally averaged costs of treating patients in specific diagnostic categories. Each of the DRGs takes into consideration the primary diagnosis, the procedure and the patient's age and condition at the time of discharge. The DRGs are weighted according to relative treatment costs

and length of stay and are then adjusted for differences in regional costs of living and wage scales. There are also adjustments allowed for extraordinary lengths and costs of stay for each DRG. Capital expenditures, education costs and outpatient services have been excluded from the DRG system and certain types of institutions, among them long-term and chronic care hospitals, psychiatric facilities and pediatric hospitals have been temporarily exempted until more precise data about their costs and patients' length of stay can be determined.

The prospective payment system is being phased in over 3 years with payments in the first year being based 75% on the hospital's own experience and only 25% on the regional averages. The hospital's specific costs will decrease as a proportion of that blend until the end of the third year when the payments will be 100% of the national rate for each illness.

The key to this DRG system is incentive. Those hospitals that can deliver a service for less than the DRG rate can keep the difference. If they overspend, the hospital will be responsible for the difference. The DRG payment will be full payment for the particular service. Hospitals are prohibited from charging Medicare beneficiaries more than the standard deductible and coinsurance amounts that the law requires them to pay as part of the Medicare agreement.

The DRG system has been given a mixed reception to date. Many hospital leaders, particularly those aligned with investor-owned institutions, have welcomed prospective payments as a means to reward cost effectiveness. Many physicians' groups, the American Medical Association among them, have been less enthusiastic, arguing that the DRGs have been inadequately tested to date. They also fear that DRGs have a potential for promoting cost-cutting measures at the expense of quality care.

What concerns many physicians is that though the DRGs are being applied initially only to the Medicare program, other third-party payers are showing acute interest in the cost containment potential of DRGs, and some states have in fact already embraced this system for non-Medicare beneficiaries.

Congress has already directed the Department of Health and Human Services to explore the possibility of devising a DRG-type system to cover the in-hospital services of physicians.

Halifax cancer clinic first to use Therac 25 accelerator

On Tuesday, Oct. 18, the Cancer Treatment and Research Foundation of Nova Scotia became the first clinic in the world to treat patients with the advanced Therac 25 Linear Accelerator.

The Therac 25, developed by AECL Medical, a division of Atomic Energy of Canada Limited, is the most efficient, versatile and compact beam-therapy unit of its kind in the world — and the Halifax cancer clinic has the only one currently licensed and operating. One has been installed at the Toronto-Bayview Clinic at Sunnybrook Medical Centre in Toronto and the first US installation will be at the East Texas Cancer Center in Tyler, Texas, in mid-December. Both are expected to be operating in early 1984.

The machine, which costs $1.5 million, uses an innovative electron waveguide system. Effective dose rates to deep-seated tumours are delivered via high-energy x-rays and accelerated electrons which minimize damage to healthy tissue.

The quality and effectiveness of the Therac 25 therapy beams are optimized by planning, set up and monitoring functions which are all controlled by an integrated computer system. The Therac 25's targeting mechanisms are extremely accurate and enhance the efficiency of the unit, which operates at 25 million volts.

"It's no different from any other form of radiation", says Dr. Dugald Thomson, executive director of the Cancer Treatment and Research Foundation of Nova Scotia. "But because of its extreme penetration you're able to get closer to the tumour without ruining surrounding tissue.

Because of this penetration, points out Dr. Thomson, the Therac 25 is unlikely to be used on patients with cancers in the neck and head area. In such areas cobalt treatment (with its equivalent 1¼ million volts) would be used. Indeed, says Dr. Thomson, the Therac 25 will never replace cobalt treatment. "It will probably only be useful on 25% of all cancer patients."

The Therac 25, like cobalt, is a painless treatment. "It's exactly like having an x-ray", says Dr. Thomson. "There's no feeling to the patient at all." But unlike an x-ray the Therac 25 is fast. Thirty seconds is all it takes per treatment.

The first patient to receive treatment from the Therac 25 had a Pancoast's tumour of the lung. The second patient was suffering from cancer of the oesophagus. The tumour in the second patient was very thick — 25 centimeters — and difficult to treat. Only 45% of cobalt treatment would have reached the tumour, says Dr. Thomson. With the Therac 25, 80% of the radiation reached the tumour.

No user fees in Nova Scotia says health minister

User fees are "not for the moment" being considered in Nova Scotia, the provinces's minister of health, Dr. Gerald Sheehy, said recently.

Dr. Sheehy also said there would be no cutbacks in the Medicare program in Nova Scotia and that the province will not withdraw from the cost-sharing arrangement with the federal government. "I've come to the conclusion", he said, "that people will stand for anything except to lose part of their medical care. Too many people in the past were ruined by medical expenses and we can't ever have that happen again.

"The public could help though", he said, "by moderating their demands on the system. Excessive demands are a bigger threat to health care than any other single item. People are asking for orthodontic coverage, dental care, eye glasses — you name it. But if we can hold back on these for the next while we should be able to maintain what we have."